Foodborne Illness Complaint Form

Incident/Outbreak ID#:_____ Complainant ID #:_____

Origin of Complaint

Date Received: _____ Receiving Agency: _____ Call Received By: _____

Complainant Data

Name: _____ DOB: _____ Gender: M F Race: W B H A Other: _____

Phone: (Work) _____ (Home) _____ (Cell) _____ (Email)_____

Occupation(s): _____ Previous Illness or Chronic Condition: Y N Existing Medications: Y N

Comments: _____

Illness Data

Illness Onset: Date: _____ Time: _____ AM / PM **Illness Stopped:** Date: _____ Time: _____ AM / PM
❑ **Illness Ongoing**

Signs and Symptoms:

❑ Diarrhea ___ Watery ___ Bloody
❑ Vomiting
❑ Nausea
❑ Abdominal Pain
❑ Fever _____ °F
❑ Chills
❑ Headache
❑ Myalgia (muscle ache)
❑ Dizziness
❑ Double Vision
❑ Jaundice
❑ Weakness
❑ Itching (location) _____
❑ Numbness (location) _____
❑ Tingling (location) _____
❑ Edema (location) _____
❑ Rash
❑ Other: _____

Diarrhea Onset: Date: _____ Time: _____ AM / PM **Diarrhea Stopped:** Date: _____ Time: _____ AM / PM
❑ **Illness Ongoing**

Vomiting Onset: Date: _____ Time: _____ AM / PM **Vomiting Stopped:** Date: _____ Time: _____ AM / PM
❑ **Illness Ongoing**

Clinical Data

Was a doctor or other healthcare provider visited? Y N

Date Visited: _____ **Time:** _____ AM / PM **Admitted:** Y N **Length of Stay:** _____ (hrs)

Healthcare Facility: _____ **Physician Name:** _____ **Phone:** _____

Were clinical specimens taken? Y N ❑ Blood ❑ Stool **Diagnosis:** _____

Would you be willing to provide a stool sample? Y N N/A – Samples no longer available

Suspect Meal Data

Date: _____ **Location:** _____ **Suspect Meal:** _____

Time: _____ AM / PM _____ _____

_____ _____

_____ _____

Number of people in party: _____ **Number of people reportedly ill:** _____ **Group Contact:** _____

(Use following page for additional contacts) **(Phone):** _____

List anything unusual about the meal (temperature, taste, color, etc.)? _____

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Other Contacts

Name		Phone	Associated Meal and/or Location
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____
_____	❑ Ill ❑ Well	_____	_____

Other Exposures

Other Possible Non-food Exposures within Past 2 Weeks: (swimming pool, river, lake, etc.)

Travel outside the US: Y N **Location(s):** _____

Water consumed outside residence: Y N **Location(s):** _____

Well water consumed: Y N **Location(s):** _____

Exposure to recreational water: Y N **Location(s):** _____

Exposure to the following:

❑ Petting zoo
❑ Mass gatherings
❑ Daycare facility
❑ Ill person at home or outside of home
❑ Domestic animals or livestock
❑ Other _____
❑ Ill animal
❑ Birds or reptiles
❑ Diapered kids or adults
❑ Visit nursing home

Notes:

_____

_____

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72-hr Food History

Day of Illness Onset: Date:

Breakfast: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Lunch: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Dinner: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Other Foods/Water: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No

One Day Prior to Illness Onset: Date:

Breakfast: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Lunch: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Dinner: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Other Foods/Water: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No

Two Days Prior to Illness Onset: Date:

Breakfast: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Lunch: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Dinner: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No
_____ Contacts: _____

Other Foods/Water: _____ Location: _____ Time: _____ AM / PM
_____ _____ Suspect Meal? ❑ Yes ❑ No